DEPARTMENT OF HEALTH CARE SERVICES

REVIEW OF MEDI-CAL PAYMENTS FOR LABORATORY SERVICES

OCTOBER 1971

Joint Legislative Audit Committee

GOVERNMENT CODE: SECTIONS 10500-10504

California Legislature

VINCENT THOMAS
CHAIRMAN

ROOM 4126, STATE CAPITOL
SACRAMENTO, CALIFORNIA 95814
(916) 445-7906

WALTER J. QUINN, C.P.A., COORDINATOR
(916) 445-1690

BILL PETTITE, CONSULTANT
(916) 445-7906

EVE OSTOJA, COMMITTEE SECRETARY
(916) 445-7908

The Honorable President of the Senate
The Honorable Speaker of the Assembly
The Honorable Members of the Senate and
The Assembly of the Legislature of California

Sirs:

Transmitted herewith is a performance audit report prepared by the Auditor General on a review of Medi-Cal payments for laboratory services. The purpose of the review was to determine whether Medi-Cal policies and procedures result in excessive reimbursements to providers of clinical laboratory services and to determine the adequacy and effectiveness of the Medi-Cal reimbursement system applied by California Blue Shield.

The report concludes that the Medi-Cal program is paying too much for clinical laboratory services. Changes in the Schedule of Maximum Allowances effective October 1, 1971 to meet the requirements of the Medi-Cal Reform Plan were inadequate. The changes affect only 16 laboratory tests out of a total of about 690 tests. In recent years, automation of clinical laboratory tests and group testing has brought about tremendous cost savings. Little of this cost saving has been passed down to the consumer-individuals, health insurance companies or governmental programs. All rates for laboratory tests need to be reviewed and adjusted to conform more closely to current costs.

It was also found that the Blue Shield payment system was cumbersome and lacking in control because of excessive manual pricing of claims for laboratory services. The Department of Health Care Services has given Blue Shield permission to set payment policy providing that the policy does not conflict with the Department's policy or that prices do not exceed the Schedule of Maximum Allowances. Blue Shield has made changes without the Department's knowledge which are in conflict with the regulations.

The report contains nine recommendations that the DHCS and California Blue Shield should follow to reduce excessive laboratory reimbursement rates and to eliminate inefficient payment procedures.

Respectfully submitted,

VINCENT THOMAS, Chairman
Joint Legislative Audit Committee

TABLE OF CONTENTS

SUMMARY OF RECOMMENDATIONS

The recommendations contained in this report are listed below in the order in which they appear:

Page

REVIEW OF MEDI-CAL PAYMENTS FOR LABORATORY SERVICES

PURPOSES OF REVIEW

The purposes of our review were:

- To determine whether Medi-Cal policies and procedures for clinical laboratory tests, as applied by California Blue Shield, result in excessive reimbursements to providers of health care services as opposed to actual laboratory costs.

- To determine the adequacy and effectiveness of the Medi-Cal reimbursement system for clinical laboratory tests, and to recommend ways and means to improve the system.

SCOPE OF REVIEW

The scope of our review consisted of:

1. Examining paid history files at California Blue Shield for actual payments made to a selected number of doctors and clinical laboratories. We tested these payments for conformance with the Schedule of Maximum Allowances (SMA), Department of Health Care Services (DHCS) policy, and California Blue Shield (CBS) policy.

2. Reviewing the report of the Senate General Research Subcommittee on Health Care Services pertaining to laboratory charges, Medi-Cal, and AB1717 (Chapter 658/70).

3. Reviewing the Department of Health Care Services plans to improve Medi-Cal payment practices for laboratory services.

4. Visiting the laboratory facilities of the Sacramento Medical Center.

We did not include a review of hospital inpatient laboratories or government laboratories, since the services performed by them were not subject to the state's Schedule of Maximum Allowances.

CONCLUSIONS

We conclude that the Medi-Cal program is paying too much for clinical laboratory services. The Department of Health Care Services has issued changes to the clinical laboratory regulation which became effective October 1, 1971 on an emergency basis. The department delayed in making the changes, and we believe that the changes made are inadequate. The regulation changes are inadequate because they affect only 16 laboratory tests out of a total of about 690 tests. The entire Schedule of Maximum Allowances should be reviewed and the rates adjusted to reflect the effect that automation has brought to the laboratory industry.

We found the Blue Shield payment system to be cumbersome and lacking in controls because of excessive manual pricing of the claims for laboratory services. Manual pricing is required to control the handling and collection fees. We also noted a variety of Blue Shield payment errors.

BACKGROUND

In recent years there has been a great deal of interest in the clinical laboratory industry. This interest has centered around the large cost savings that are available due to technological improvements in the industry. Automated and semi-automated equipment has been invented which eliminates the need for costly manual testing and provides volume production. Little of this cost savings has been passed down to the consumer - the private citizen, the health insurance company, or the government programs such as Medi-Cal.

The problem is to determine and prescribe a fair rate or fee for Medi-Cal to pay for laboratory services performed. The 1970 California Legislature passed AB 1717 (Chapter 658/70) which added Section 655.5 to the Business and Professions Code, requiring doctors and other providers of health care services to fully disclose to the patient the cost of services and the name and addresses of the clinical laboratory performing the services where the laboratory work was done outside of the provider's office. The intent of AB 1717 was to prevent a provider from making exorbitant laboratory charges to patients on outside laboratory services by hiding his true laboratory costs. The statute became effective November 23, 1970.

The Senate General Research Subcommittee on Health Care Services issued a report dated March 1, 1971, after studying laboratory fees, the

possible overuse of laboratory services, and the effect of such use on Medi-Cal costs and health costs in general. The study included public hearings in Los Angeles during October and December 1970.

The subcommittee's report noted that the clinical laboratory industry is a large, rapidly expanding business. Two major factions of the industry are battling for this expanding market - the small "local" laboratory on the one hand, and the large regional and chain laboratories on the other hand. Since the invention of the SMA-12 Autoanalyzer (which can be purchased for about $60,000) and other similar automated machines, the small laboratory can compete in price with the larger laboratories if it chooses to do so. The subcommittee stated that government intervention has altered the patterns of choice and utilization of laboratory services; that this intervention has disrupted normal competitive pricing of laboratory charges and has thereby subsidized uneconomic and inefficient segments of the industry.

The subcommittee further reported that the state's 1966 and 1970 schedules of maximum allowances, the guide for Medi-Cal payments, have largely ignored changes in clinical laboratory technology and do not reflect the direct costs of laboratory tests.

The subcommittee concluded with regard to Medi-Cal payments that:

"1. The reimbursement policies for the Medi-Cal Program have encouraged some physicians and laboratories to profit excessively.

"2. The Schedule of Maximum Allowances bears little relationship to the direct cost of performing laboratory procedures.

"3. The State has paid more than what is equitable for laboratory services rendered by both physicians and laboratories.

"4. Savings to Medi-Cal by physicians and laboratories who bill significantly less than the Schedule of Maximum Allowances have not been fully realized.

"5. The lack of adequate controls on Medi-Cal reimbursements has permitted the Schedule of Maximum Allowances to be exceeded, and has allowed arbitrary payment practices.

"6. Present Medi-Cal regulations make it virtually impossible to administer laboratory reimbursements on an efficient and rationalized basis."

With regard to AB1717, the subcommittee concluded that:

"1. Physicians have devised numerous ways to avoid having to comply with the provisions of AB 1717. This circumvention of AB 1717 has altered the previous patterns of choice and utilization of laboratory services resulting in (a) increased direct cost of laboratory services to the patient, and to the physician, (b) increased cost of laboratory services to Medi-Cal, (c) and has accelerated the formation and spread of physician owned laboratories.

"2. Created major change in the laboratory industry presenting far greater problems than AB 1717 was intended to solve.

"3. Inadvertently created problems for certain providers of laboratory services."

The Department of Health Care Services has also studied laboratory charges and has formulated some changes to Title 22 of the California Administrative Code. The changes were formulated with the advice of an ad hoc committee consisting of seven members of the laboratory industry and became effective October 1, 1971. These changes are discussed more fully under the heading of DHCS Regulation Changes later in this report.

FINDINGS AND RECOMMENDATIONS

SENATE SUBCOMMITTEE RECOMMENDATIONS

The subcommittee recommended the following changes in Medi-Cal reimbursement policies for clinical laboratory services:

"1. Elimination of the drawing and handling allowables.

"2. Enactment of a regulation requiring the party who collects the specimen to bill Medi-Cal for the laboratory services.

"3. Establishment of a new Schedule of Maximum Allowances based upon a global fee. Laboratory procedures would be reimbursed at one fixed rate; reimbursed to the biller who collected the specimen, regardless of the cost of that procedure to the biller. If the procedure was tested in conjunction with one or more tests, then the allowable for each additional test should be significantly reduced, reflecting the effects of volume and or automated testing, and the economies of administering a battery of tests.

"4. Establishment of an advisory committee to the Department of Health Care Services to conduct continuing cost test studies and to recommend changes in the Schedule of Maximum Allowances based upon changes in the laboratory industry. Representatives of all segments of the laboratory, and physicians, should constitute the advisory committee."

The subcommittee made the following recommendations pertaining to AB1717:

"1. Repeal of AB 1717.

"2. Add an amendment to the Business and Professions Code permitting a patient who believes he has been charged excessively for referral laboratory services to take a complaint to the Board of Medical Examiners, or a subdivision thereof, and permit the Board of Medical Examiners to adjust and/or reconcile the complaint. The Board of Medical Examiners would be authorized to take disciplinary action against physicians who charged the patient excessively.

"3. Prohibit physician ownership of laboratory cooperatives, and require other physician owned laboratories to file profit and loss statements with the Department of Public Health."

We support the Senate subcommittee's first four recommendations relating to Medi-Cal reimbursement policies. Initially the department also agreed with these recommendations, but reinstated the drawing and handling fee (not exceeding three dollars) when the regulation changes were issued. The new regulations require the party who collects the specimen to bill Medi-Cal. The department has made some changes to the reimbursement rates and worked with an advisory committee as recommended.

We do not believe that AB 1717 should be repealed. We believe that if a physician is allowed to bill Medi-Cal at a reasonable maximum allowable rate, established after a thorough study, the physician will shop for the most competitive price because he will maximize his profit by paying less for the laboratory test.

In lieu of the provisions of AB 1717, the subcommittee recommended amending the Business and Professions Code permitting a patient to file a complaint with the Board of Medical Examiners if he feels he has been overcharged. Such provision is probably too weak to be effective.

The last recommendation pertains to physician-owned laboratory cooperatives and other physician-owned laboratories. The matter of conflict of interest was not in the scope of our review. However, it is apparent that some statutory control should be provided because the medical profession apparently is unable to effectively control this practice.

DHCS REGULATION CHANGES

In the latter part of September 1971, the department issued numerous changes to Title 22 of the California Administrative Code on an emergency

basis. The changes were made effective October 1, 1971, and were implemented mainly to meet requirements of the recently enacted Medi-Cal Reform Plan (Ch. 577/1971). Regulation changes pertaining to laboratory services were combined with the reform changes and consist of:

1. Reimbursing the provider for the lesser of: the amount billed, the charge to the general public, the maximum allowable rate, or the cost to the provider when the tests are done by an outside laboratory, plus reasonable charges not to exceed $3.00 for collecting and handling specimens.

2. Requiring billings to be made only by the provider collecting the specimen.

3. Setting maximum reimbursement rates on two common panel or multiple tests affecting 16 blood chemistries.

4. Substituting one schedule of maximum reimbursement rates for two previous schedules covering hospital outpatient laboratories and clinical laboratories.

We believe that the changes made do not accomplish enough and that more meaningful changes should have been implemented sooner. Testimony given to the Senate subcommittee in December 1970, indicated that the department intended to make broader changes that were to be ready for advertising on February 1, 1971.

Actually, the laboratory regulation changes were not advertised and public hearings were not held. Instead, the changes were enacted as emergency

regulations effective October 1, 1971, along with regulations resulting from the Medi-Cal Reform Plan.

The department has the necessary personnel to determine reasonable reimbursement rates and to establish sound regulations.

Panel or Multiple Tests

The regulation changes reduce Medi-Cal costs for two common panel tests referred to as the SMA-12 test and the Electrolyte test. In the past it was possible for a provider to bill Medi-Cal for each individual test within a panel despite the fact that the entire panel or any part of the panel can be tested simultaneously by automated methods. There are almost countless combinations of possible panel tests. (Blue Shield lists 13 panels in its Medi-Cal Policy Manual.) The department has chosen to control only these two common panel tests for the present.

We believe that more savings can be realized by controlling payments for all laboratory procedures that can be easily tested in panels. The California Blue Shield 1964-1969 Relative Value Studies Correlation Manual lists 22 blood chemistries that can readily be "panelized". The SMA-12 and Electrolyte tests include 16 of these 22 chemistries. As a minimum, the remaining six chemistries could be controlled by imposing a $5.00 maximum for any one test and $1.50 for each additional test.

RECOMMENDATION

1. Develop and set up reimbursement rates for more multiple or panel tests.

Schedule of Maximum Reimbursement Rates

The department's new schedule of maximum reimbursement rates replaces two former rate schedules. Previously the physicians and clinical laboratories were reimbursed in accordance with the Schedule of Maximum Allowances, Section I, Laboratory Services. Hospitals were reimbursed for outpatient laboratory services in accordance with Section 51509(d), Title 22, California Administrative Code.

The new schedule has the same rates as the old SMA except for the rate changes for the 16 blood chemistries in the SMA-12 and Electrolyte panel tests. We noted the following deficiencies in the new schedule:

1. Basically the new schedule contains rates which have not been changed since September 1966, despite marked developments in the automation of laboratory techniques. All of the rates need to be reviewed and adjusted to conform more closely to current costs.

2. The new schedule uses 1964 RVS (California Relative Value Studies) procedure codes, not the 1969 RVS codes. Presently Blue Shield allows the providers to use either code when billing. Blue Shield then converts the 1969 RVS billings received into the old 1964 RVS procedure codes. The result is a constant, unnecessary conversion process both manually and by the computer especially since the 1964 RVS procedure codes do not contain all the procedures now in use by the industry. We believe that the 1969 RVS codes should be adopted and that the providers should be required to use them.

3. The 1969 RVS lists 430 more laboratory tests than the 1964 RVS. These additional tests are not included in the new schedule and presently are not included in Blue Shield's computer price listing.

4. The department testified before the Senate subcommittee in December 1970, that its intention is to designate maximum fees for all automated laboratory tests. These fees were to be based on a study of independent automated laboratory charges and would be ready for advertising by February 1, 1971.

The department has not complied with the plan outlined to the Senate subcommittee. It did not follow through on a study of independent automated laboratory charges, nor did it determine a maximum fee for all automated laboratory tests. The department did attempt a study of laboratory charges by the use of questionnaires but later dropped it. The use of questionnaires to establish rates was dropped because the department considered the responses to be statistically inadequate.

The department should not drop its plans to develop a maximum fee for all automated laboratory tests. The potential savings are too great to do so. If the questionnaire method is invalid, the department should develop another method. Our review disclosed that the automated laboratories have two fee schedules, one which might be called a wholesale schedule for physicians and other clinical laboratories, and the second a retail schedule used to bill the patient or Medi-Cal. We suggest that the department get a comprehensive cross section of the wholesale schedules and develop its maximum reimbursement schedule from this source.

RECOMMENDATIONS

2. Review and set maximum reimbursement rates for all laboratory procedures listed in the 1969 RVS.

3. Adopt the 1969 RVS coding and instruct Blue Shield to require the providers to submit all laboratory claims with 1969 RVS codes.

4. Annually review and update the reimbursement rate schedule where appropriate.

CALIFORNIA BLUE SHIELD

Our review of selected payments for laboratory services made by California Blue Shield disclosed both lack of departmental control over Blue Shield and lack of Blue Shield control over its payment process.

DHCS Payment Policy

Prior to the regulation changes, Blue Shield used the Schedule of Maximum Allowances and Blue Shield Medical Policy Manual guidelines to pay Medi-Cal laboratory bills. The DHCS has given Blue Shield informal permission to follow Blue Shield policy provided that it does not exceed or conflict with the SMA. We noted two recent changes in Blue Shield policy which were made without DHCS knowledge and which conflict with the DHCS regulation changes.

The changes pertain to the collection and handling fee and to panel (multiple) testing. In February 1971, Blue Shield raised the handling fee to a maximum of $5.00 for a simple blood sample. Previously Blue Shield paid

$3.00 in accordance with the 1969 RVS, but would pay up to $5.00 per day for multiple blood samples. In August 1971, Blue Shield issued new guidelines for payment of laboratory panel tests. The guidelines, for the most part, are more liberal than the department's new regulations.

These two changes indicate the lack of communications and coordination between Blue Shield and the department. They also illustrate the department's limited control over the Medi-Cal payments. The department should be setting all payment policy, based on the cooperation, coordination, and knowledge of Blue Shield. A manual clearly stating the department's policies and procedures is badly needed. An effective monitoring system is also needed to determine that laboratory fees are being paid according to department guidelines.

RECOMMENDATIONS

5. Prepare a policy manual with the advice and cooperation of Blue Shield, that clearly shows the department's payment policies.

6. Periodically monitor the Medi-Cal laboratory payments for Blue Shield compliance with policy guidelines.

Blue Shield Payment Process

We noted a variety of types of errors in our review of the Medi-Cal laboratory claim payments made by Blue Shield. Many of these errors are the result of manual processing. Eliminating the collection and handling fee and eliminating split billings should reduce the need for manual processing and provide more efficient use of the computer. We noted the following.

Computer Override Codes. A large percentage of laboratory claims are paid by the use of override codes. Override codes are used by Blue Shield employees to eliminate certain computer audit steps (edits). Blue Shield raised the collection and handling fee from $3.00 to $5.00 but did not change the $3.00 rate in the computer. This necessitated manual pricing and the use of an override code so that the claims would bypass the computer price edit. Later on in the processing, the computer makes a price variance edit. A claim with a large variance between manual and computer price will be rejected by the computer and will require recycling and an override code before it can be paid. This is inefficient. The new rate should be in the computer, assuming that the new rate has DHCS approval.

RECOMMENDATION

7. Require that Blue Shield promptly enter all authorized reimbursement rates or rate changes into its computer.

Incorrect Claim Payments. We noted that Blue Shield made the following payment errors:

a. In several cases, blood panel tests were not paid as a single panel but were paid as individual components of the panel at SMA rates.

b. In many instances, collection and handling fees were paid on Pap smear or urine specimens, which is contrary to the Blue Shield policy manual.

c. In several instances, the combined prices of the laboratory test and the collection and handling of the specimen exceeded the SMA.

d. An automated laboratory was reimbursed by Medi-Cal in excess of the fee allowed for the particular procedure test. Also, a number of lab tests reported by Blue Shield in its paid laboratory procedures printout for November 1970, disclosed that actual payments to physicians and physician-owned laboratories were in excess of the maximum reimbursement fees for the laboratory procedures involved.

RECOMMENDATION

8. Require that Blue Shield provide an effective method of enforcing the Medi-Cal directives prescribed in its Medical Policy Manual.

Catch-all Codes. Blue Shield uses one "catch-all" procedure code to price each of the several blood chemistries listed in the 1969 RVS that are not found in the SMA, another "catch-all" procedure code for microbiology procedures, and so on.

The method employed by Blue Shield to price the above procedure tests, makes it time-consuming and difficult to identify individual tests that are part of a standard panel.

It would improve the accuracy and efficiency of the payment procedure to assign individual procedure codes and establish the customary rates for each of these procedure tests rather than to have one catch-all code to cover many different tests having different prices. The Medi-Cal pricing master list

maintained by Blue Shield should be revised to delete the catch-all codes and to add to the list the new individually assigned codes.

RECOMMENDATION

9. Require that Blue Shield discontinue the use of "catch-all" procedure codes and assign additional code numbers where needed.

William H. Merrifield
Auditor General

December 3, 1971